		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037143

Facility Name: Illini Hospital Nursing Home

Address: 1455 Hospital Road (Number) Silvis (City) 61282 (Zip Code)

County: Rock Island

Telephone Number: (309) 792-7614 **Fax #** (309) 792-7611

IDPA ID Number: 36-3616314001

Date of Initial License for Current Owners: 08/12/1991

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kay Marsyla **Telephone Number:** (563) 421-1985

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Kleinschmidt
(Title) Vice President, Finance, Genesis Health System

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Kay Marsyla, Manager, Finanacial Planning and Reimbursement
(Firm Name & Address) Genesis Health System, 1227 E. Rusholme St., Daveneport, IA 52804
(Telephone) (563) 421-1985 Fax # (563) 421-1999

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	67	Skilled (SNF)	67	24,455	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	53	Sheltered Care (SC)	53	19,345	5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		447	6,404	6,851	8
9	SNF/PED					9
10	ICF	5,593	10,191		15,784	10
11	ICF/DD					11
12	SC		16,470		16,470	12
13	DD 16 OR LESS					13
14	TOTALS	5,593	27,108	6,404	39,105	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.28%

D. How many bed-hold days during this year were paid by Public Aid?
12 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 08/12/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 08/12/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 22 and days of care provided 6,851

Medicare Intermediary Cahaba GBA

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary											1
2	Food Purchase		625,044		625,044		625,044	2,576	627,620			2
3	Housekeeping		10,413	223,518	233,931		233,931	(54,659)	179,272			3
4	Laundry											4
5	Heat and Other Utilities			105,521	105,521		105,521		105,521			5
6	Maintenance		12,573	126,214	138,787		138,787	(103,287)	35,500			6
7	Other (specify):* **Cafeteria**							95,501	95,501			7
8	**TOTAL General Services**		648,030	455,253	1,103,283		1,103,283	(59,869)	1,043,414			8
	B. Health Care and Programs											
9	Medical Director			9,663	9,663		9,663		9,663			9
10	Nursing and Medical Records	1,686,129	19,503	47,061	1,752,693		1,752,693	(15,109)	1,737,584			10
10a	Therapy	44,013	144	302,686	346,843		346,843		346,843			10a
11	Activities	72,359	8,647	6,962	87,968		87,968		87,968			11
12	Social Services	63,306	44	1,659	65,009		65,009		65,009			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,865,807	28,338	368,031	2,262,176		2,262,176	(15,109)	2,247,067			16
	C. General Administration											
17	Administrative	102,709	3,558	5,145	111,412		111,412	1,340,424	1,451,836			17
18	Directors Fees											18
19	Professional Services			79,622	79,622		79,622		79,622			19
20	Dues, Fees, Subscriptions & Promotions			7,002	7,002		7,002		7,002			20
21	Clerical & General Office Expenses	187,853	4,075	411,543	603,471		603,471	(124)	603,347			21
22	Employee Benefits & Payroll Taxes			393,371	393,371		393,371		393,371			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,477	7,477		7,477		7,477			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			177,880	177,880		177,880		177,880			26
27	Other (specify):* **Other Acctg/Audit**			453,569	453,569		453,569		453,569			27
28	**TOTAL General Administration**	290,562	7,633	1,535,609	1,833,804		1,833,804	1,340,300	3,174,104			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,156,369	684,001	2,358,893	5,199,263		5,199,263	1,265,322	6,464,585			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Illini Hospital Nursing Home #0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			283,654	283,654		283,654		283,654			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			582,716	582,716		582,716	(28,448)	554,268			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,316	22,316		22,316		22,316			35
36	Other (specify):* **Amort of Bonds**			5,871	5,871		5,871		5,871			36
37	**TOTAL Ownership**			894,557	894,557		894,557	(28,448)	866,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		289,412		289,412		289,412		289,412			39
40	Barber and Beauty Shops			11,544	11,544		11,544		11,544			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		289,412	11,544	300,956		300,956		300,956			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,156,369	973,413	3,264,994	6,394,776		6,394,776	1,236,874	7,631,650			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(28,448)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(41,708)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,156)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,307,030		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,307,030		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,236,874		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Illini Hospital Nursing Home

ID# 0037143

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (124)	21	1
2	Misc Income	(15,109)	10	2
3	Misc Income	(1,010)	3	3
4	Misc Income	(25,465)	6	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(41,708)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	2,576	0	0	0	0	0	0	0	0	0	2,576	2
3	Housekeeping	(1,010)	(53,649)	0	0	0	0	0	0	0	0	0	(54,659)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(25,465)	(77,822)	0	0	0	0	0	0	0	0	0	(103,287)	6
7	Other (specify):*	0	95,501	0	0	0	0	0	0	0	0	0	95,501	7
8	**TOTAL General Services**	(26,475)	(33,394)	0	0	0	0	0	0	0	0	0	(59,869)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(15,109)	0	0	0	0	0	0	0	0	0	0	(15,109)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(15,109)	0	0	0	0	0	0	0	0	0	0	(15,109)	16
	C. General Administration													
17	Administrative	0	1,340,424	0	0	0	0	0	0	0	0	0	1,340,424	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(124)	0	0	0	0	0	0	0	0	0	0	(124)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(124)	1,340,424	0	0	0	0	0	0	0	0	0	1,340,300	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,708)	1,307,030	0	0	0	0	0	0	0	0	0	1,265,322	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Illini Hospital Nursing Home** **#** **0037143** **Report Period Beginning:** **07/01/02** **Ending:** **06/30/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**(28,448)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(28,448)**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**(28,448)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(28,448)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(70,156)**	**1,307,030**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,236,874**	**45**

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illini Nursing Home	100%	Illini Restorative Care Center	Silvis	Illini Hospital	Silvis	Hospital
				Crosstown Square	Silvis	Senior Apts
				Genesis Health System	Davenport, IA	Home Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Dietary Grocery 85010-37000	$ 340,574	Illini Hospital (B, Pt I allocated cost)	100.00%	$ 595,351	$ 254,777	1
2	V	2	Dietary Grocery 85030-37000	252,201	Illini Hospital (B, Pt I allocated cost)	100.00%		(252,201)	2
3	V	3	Housekeeping 85510-54800	174,903	Illini Hospital (B, Pt I allocated cost)	100.00%	167,803	(7,100)	3
4	V	3	Housekeeping 85530-54800	46,549	Illini Hospital (B, Pt I allocated cost)	100.00%		(46,549)	4
5	V	6	Security 86710 & 86730-54800	13,526	Illini Hospital (B, Pt I allocated cost)	100.00%		(13,526)	5
6	V	6	Maint 86010 & 86030-54800	64,296	Illini Hospital (B, Pt I allocated cost)	100.00%		(64,296)	6
7	V	17	Admin 80010-54800	58,152	Illini Hospital (B, Pt I allocated cost)	100.00%	1,402,686	1,344,534	7
8	V	17	Admin 80030-54800	4,110	Illini Hospital (B, Pt I allocated cost)	100.00%		(4,110)	8
9	V	29	Overhead Alloc 80010-69500	185,122	A-8-1 Home Office Cost Report	Affiliated	185,122		9
10	V	29	Overhead Alloc 80030-69500	52,214	A-8-1 Home Office Cost Report	Affiliated	52,214		10
11	V	29	Overhead IT 80010-69550	98,462	A-8-1 Home Office Cost Report	Affiliated	98,462		11
12	V	29	Overhead IT 80030-69550	27,771	A-8-1 Home Office Cost Report	Affiliated	27,771		12
13	V	7	Cafeteria		Illini Hospital (B, Pt I allocated cost)	100.00%	95,501	95,501	13
14	Total			$ 1,317,880			$ 2,624,910	$ * 1,307,030	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Illini Hospital
Street Address: 801 Hospital Road
City / State / Zip Code: Silvis, IL 61282
Phone Number: (309) 792-4268
Fax Number: (309) 792-4274

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Dietary Groceries	Meals Served	400,195	3	$ 2,942,274	$ 508,591	80,977	$ 595,351	1
2	3	Housekeeping	Square Feet	153,579	3	1,124,927	624,995	22,909	167,803	2
3	19	Allocated Hospital Admin	Accum Cost	46,558,453	3	10,256,510	2,732,213	6,367,360	1,402,686	3
4	22	Allocated Café Costs	FTE's Served	46,167	3	714,583		6,170	95,501	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 15,038,294	$ 3,865,799		$ 2,261,341	25

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Pacific Commonwealth		x			4/99	$ 8,816,721	$ 8,682,216	11/01/40	6.5000	$ 582,714	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 8,816,721	$ 8,682,216			$ 582,714	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 8,816,721	$ 8,682,216			$ 582,714	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 52,653 **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illini Hospital Nursing Home COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0037143

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,055 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	157,252	1991	$ 13,074	1
2	Nursing Home	63,650	1999	20,368	2
3	TOTALS	220,902		$ 33,442	3

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	67			1991	$ 1,933,738	$ 72,168	40	$ 72,168	$	$ 1,043,863	4
5	53			2000	5,239,215	130,980	40	130,980		375,198	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvement - 10 year #1, #2, #102, #189			1991	12,671		10			12,671	9
10	Land Improvement - 15 #187			1991	27,738	1,849	15	1,849		22,652	10
11	Carpet #239			1992	438		5			438	11
12	Vinyl Floorings # 240			1992	578	29	20	29		304	12
13	Chandelier # 241			1992	492	49	10	49		524	13
14	Wallpaper #244			1992	3,326		5			3,326	14
15	Signage #243			1993	1,305	109	12	109		1,134	15
16	Alarm System #247			1992	587	39	15	39		413	16
17	Smoke Door Hood #249			1992	779	78	10	78		838	17
18	Central Dumpster #250			1992	465	47	10	47		543	18
19	New Seeding/Mulch #261, #262			1993	12,415	1,243	10	1,243		12,318	19
20	Repair Sidewalk #274			1994	1,874	125	15	125		1,166	20
21	Circuit Panel A/C Outlet #265			1993	930	93	10	93		915	21
22	Install A/C #275			1994	498	50	10	50		466	22
23	FY95 Addtions #278, #292, #294			1995	7,072	504	15	504		4,390	23
24	PT Therapy Utility Construction #305			1996	142,757	9,517	15	9,517		78,516	24
25	Canvas Awning #306 & Decorative Lighting #307			1996	29,660	1,848	15	1,848		13,118	25
26	Emerson #308			1996	594	59	10	59		488	26
27	Parking Lot Repair #317			1997	3,561	445	5	445		2,997	27
28	Major Repair IRC Boiler #319			1997	9,872	657	7	657		10,529	28
29	Directory Board #327			1997	797	79	5	79		557	29
30	Remodel IRC Nurse Station #330			1997	3,340	222	15	222		1,372	30
31	Cabinets-Stroage-Utility Room #331			1997	4,103	273	15	273		1,685	31
32	Carpet #329			1997	1,440		5			1,440	32
33	Hot Water Tank #328			1997	1,749	175	5	175		1,224	33
34	Tank #312			1996	2,650	265	10	265		1,921	34
35	Air compressor for Chiller #335			1997	14,196	947	15	947		4,338	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Double Egress Doors #341	1998	$ 2,756	$ 183	15	$ 183	$	$ 946	37
38	Landscaping #352	1999	2,176	218	10	218		981	38
39	Carpet Lobby & Office Areas #361	1999	3,123	625	5	625		2,812	39
40	Tie-In Peping Hot Water to IRC #372	1999	1,766	88	20	88		396	40
41	Install VPI Bse & Ceramic Tile #376	1999	1,385	139	10	139		625	41
42	Lock Sets mastered to Key #349	1999	2,642	528	5	528		2,376	42
43	Wook Replacement Doors #388	2000	1,308	88	15	88		306	43
44	4" Sprinkler System #397	2000	18,675	747	25	747		2,615	44
45	Concrete Replacement #444	2001	2,239	149	15	149		373	45
46	IRC Roof Hatches #435	2001	2,420	242	10	242		605	46
47	Door and Door Closers Exam Room #440	2001	1,524	102	15	102		255	47
48	Activities Office-Paint, Wallpaper, Carpet #442	2001	1,926	385	5	385		963	48
49	Carpentry Patient Room Showers #443	2001	9,326	622	15	622		1,555	49
50	Air cond/Handling Unit3-Way Control Val #433	2001	2,187	219	10	219		547	50
51	IRC Boiler Stack #438	2001	14,750	738	20	738		1,845	51
52	PA Systme IRC Dining Room #439	2001	1,682	168	10	168		420	52
53	Date Voice Wiring-SC #412	2001	31,453	3,145	10	3,145		7,863	53
54	Door Alarm - SC #413	2001	2,211	221	10	221		553	54
55	Analog Messge -SC #414	2001	2,693	269	10	269		673	55
56	Phone System-SC	2001	25,643	2,564	10	2,564		6,410	56
57	Nurse Call System - SC #436	2001	6,498	650	10	650		1,625	57
58	Kitchen Cabinets-SC #437	2001	4,077	272	15	272		1,058	58
59	Refrigerator, Washer, Dryer-SC #422l,#423,#424	2001	1,665	185	10	185		460	59
60	Phones-SC #423,#427,#428	2001	4,224	845	5	845		2,112	60
61	Bearuty Shop-SC #425	2001	1,621	162	10	162		405	61
62	Parking Lot-NW Area-Asphalt & Lights #462, #463	2002	53,929	5,393	10	5,393		8,644	62
63	IRC Bldg Improv #451,#453,#454,#455,#456,#510	2002	17,485	1,749	10	1,749		2,515	63
64	IRC Hallway Carpet #464	2002	10,072	2,014	5	2,014		3,021	64
65	IRC Wooken Door #455, Bedban Washers #450	2002	4,388	293	15	293		439	65
66	IRC Switchboard cable #458, Boiler Fail over #461	2002	6,736	674	10	674		1,011	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,701,420	$ 245,526		$ 245,526	$	$ 1,653,753	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,701,420	$ 245,526		$ 245,526	$	$ 1,653,753	1
2	Security System #513	2003	6,267	209	15	209		209	2
3	IRC Loading #626	2003	97,613	2,440	20	2,440		2,440	3
4	Parking Garage #518	2003	13,364	334	20	334		334	4
5	Bronze Cir #512	2003	1,937	97	10	97		97	5
6	Air Condit #516	2003	2,755	138	10	138		138	6
7	IRC Door Alarm #517	2003	5,792	290	10	290		290	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,829,148	$ 249,033		$ 249,033	$	$ 1,657,261	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 768,590	$ 36,947	$ 36,947	$		$ 450,355	71
72	Current Year Purchases	4,840	968	968			968	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 773,430	$ 37,915	$ 37,915	$		$ 451,323	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Van, Ford 1991	1991	$ 33,800	$	$	$		$ 33,800	76
77										77
78										78
79										79
80	TOTALS			$ 33,800	$	$	$		$ 33,800	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,669,820	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 286,948	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 286,948	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,142,384	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 22,316 Description: PT, Nursing Admin, Nursing Floor, Maintenance Rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 1-3	hrs	$		$	$ 126		$ 126	1
2	Licensed Speech and Language Development Therapist	10a, 1-3	hrs			6,907	7		6,914	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1-3	hrs	44,012		295,778	7		339,797	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				160,036		160,036	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Chg Med Supplies	39					129,376		129,376	13
14	TOTAL			$ 44,012		$ 302,685	$ 289,552		$ 636,249	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Illini Hospital Nursing Home **#** 0037143 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,378,450	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	454,436		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	594,927		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	24,797		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,452,610	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	312,815		13
14	Buildings, at Historical Cost	11,565,169		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,111,803		16
17	Accumulated Depreciation (book methods)	(4,554,187)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe unamort bond issue c	423,872		22
23	Other(specify): CIP	136,698		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,996,170	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,448,780	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 660,104	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	527		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,427		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	22,576		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Third Party Settlements	201,076		36
37	Other Accrued Expense	139,418		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,243,128	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	347,327		39
40	Mortgage Payable			40
41	Bonds Payable	11,815,716		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,163,043	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,406,171	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,957,391)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,448,780	$	48

***(See instructions.)**

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,613,610)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,613,610)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(343,390)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (343,390)	17
	B. Transfers (Itemize):		
18	Misc	(391)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (391)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,957,391)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,539,524	1
2	Discounts and Allowances for all Levels	(2,315,225)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,224,299	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,762,675	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,762,675	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	72,188	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 72,188	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Resident Net income	(7,776)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (7,776)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,051,386	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,103,283	31
32	Health Care	2,262,176	32
33	General Administration	1,833,804	33
	B. Capital Expense		
34	Ownership	894,557	34
	C. Ancillary Expense		
35	Special Cost Centers	300,956	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,394,776	40
41	**Income before Income Taxes (line 30 minus line 40)****	(343,390)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (343,390)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,888	4,322	$ 105,226	$ 24.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,754	12,895	276,387	21.43	3
4	Licensed Practical Nurses	29,962	31,815	503,971	15.84	4
5	Nurse Aides & Orderlies	73,765	79,390	813,562	10.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,514	3,984	46,917	11.78	8
9	Activity Director	2,115	2,218	30,094	13.57	9
10	Activity Assistants	4,857	5,280	48,686	9.22	10
11	Social Service Workers	3,949	4,275	45,078	10.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,131	2,137	113,603	53.16	20
21	Assistant Administrator					21
22	Other Administrative	4,009	4,390	90,634	20.65	22
23	Office Manager	1,894	2,036	37,887	18.61	23
24	Clerical	3,206	3,438	39,058	11.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,506	4,018	46,848	11.66	31
32	Other Health Care(specify)					32
33	Other(specify) Staff dev coord	2,290	2,353	45,527	19.35	33
34	TOTAL (lines 1 - 33)	150,840	162,551	$ 2,243,478 *	$ 13.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbra Mask			$ 102,709
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,709

B. Administrative - Other

Description	Amount
Other 80010-69990	$ 5,145
TOTAL (agree to Schedule V, line 17, col. 3)	$ 5,145
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Illini Hospital 80010-54800	Mgt Svc	$ 58,152
Illini Hospital 80010-45000	Professional	17,360
Illini Hospital 80030-45000	Professional	0
Illini Hospital 80030-54800	Mgt Svc	4,110
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 79,622

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	162,142
Employee Health Insurance	102,245
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	69,394
Life Insurane	3,829
LT Disability	13,665
EAP	2,601
Employee Physical	4,467
Misc	21,210
TOTAL (agree to Schedule V, line 22, col.8)	$ 379,553

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising 68110-62000	58
IL Council on LTC	3,704
INHA	78
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,840

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,182
Seminar Expense	5,295
Entertainment Expense	7,477
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,954

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $3,704 & INHA $75**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,621** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **0**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **Yes** Has any meal income been offset against related costs? **Net in Alloc** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **NA**
Attach invoices and a summary of services for all architect and appraisal fees.